Department of Health
Early Intervention Services

Performance Report

Performance Period April 2005–June 2005

Introduction

This report presents information about the performance of operations and services of the Early Intervention Section (EIS) and Healthy Start from April through June 2005.

Data are presented in six performance areas:

- *Enrollment:* Data are provided on the number of children who were served, by island and statewide.
- *Service Gaps:* Data include the number of Part C eligible infants and toddlers who experienced service gaps, by island and statewide.
- *Personnel:* Information on personnel, by island and statewide, is collected to ensure there are sufficient personnel to serve the eligible population. Personnel data for EIS are divided by roles: social work, direct service, and central administration. Caseload data include the number and percentage of social workers that have weighted caseloads of no more than 1:45. Personnel data for Healthy Start staff (central administration positions) are provided.
- *Training Opportunities:* Training data include the number of early intervention (EI) staff, families, and other community providers (including Department of Education preschool special education teachers, community preschool staff, etc.) who participated in training activities. Information includes trainings provided or supported by EIS and Healthy Start.
- *Quality Assurance:* Information on quality assurance activities for EIS and Healthy Start are provided.
- *Funding:* Data on appropriations, allocations, and expenditures are provided.

Strengths and challenges to the early intervention system for April through June 2005 are summarized.

Enrollment

Early Intervention Section

Monthly Enrollment

Monthly enrollment data for infants and toddlers served by EIS from April through June 2005 are shown in Table 1.

Table 1. EIS Monthly Enrollment Data

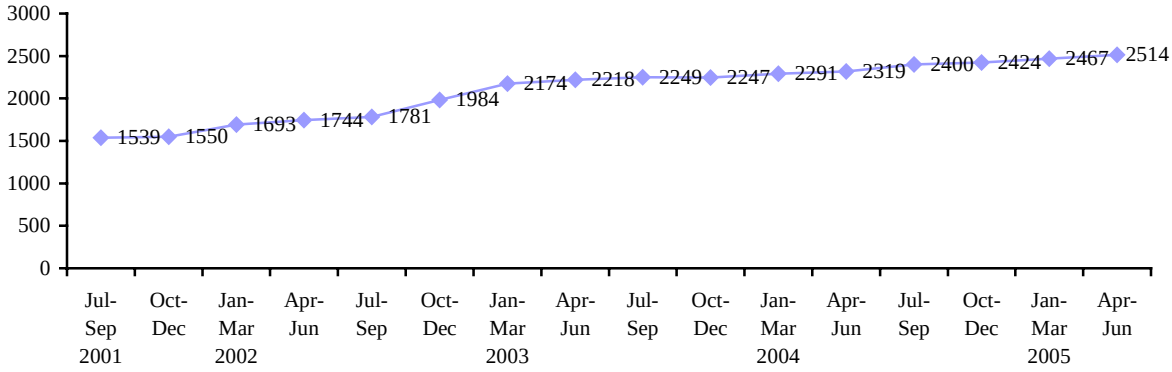
Month	Monthly Enrollment	Island					
		Oahu	Hawaii	Maui	Kauai	Molokai	Lanai
April 2005	2526	1800	278	255	152	32	9
May 2005	2515	1779	289	222	161	24	7
June 2005	2501	1749	313	253	159	22	5

Note: Enrollment information includes children provided care coordination by EIS (including Early Childhood Services Programs[ECSP]), Purchase of Service programs (POSP), and Public Health Nurses (PHN).

Quarterly Enrollment

The quarterly enrollments (average monthly enrollment for the quarter) since July 2001 are shown in Graph 1. Average enrollment data for the April-June 2005 quarter increased from 2,467 to 2,514 children, an increase of 1.9% from the previous quarter's average. There continues to be slight quarterly increases in the number of children identified with developmental delays or at biological risk.

Graph 1. EIS Quarterly Enrollment from July 2001 to June 2005



Child Find

Child find activities continue and, based on the increasing number of infants and toddlers identified with developmental delays, are successful in informing new providers, pediatricians, and families about Hawaii's early intervention system and how to make a referral to the system. In addition to child find activities, trainings to community preschool teachers, day care providers and other community providers expand the knowledge of early intervention and the referral process to community providers (see section on Training Opportunities).

The EIS website, which was launched in May 2004, continues to expand awareness of Hawaii's early intervention program not only to Hawaii residents, but nationwide. The

website has an automatic link to the H-KISS referral form to simplify referrals. The website is still being expanded to provide other relevant information.

EIS continues to provide H-KISS brochures to the Healthy Start Early Identification Units to distribute to families who are either ineligible for Healthy Start or choose not to enroll in the program.

Participation in the Special Parent Information Network (SPIN) Conference increases the awareness of families and staff about early intervention.

Healthy Start

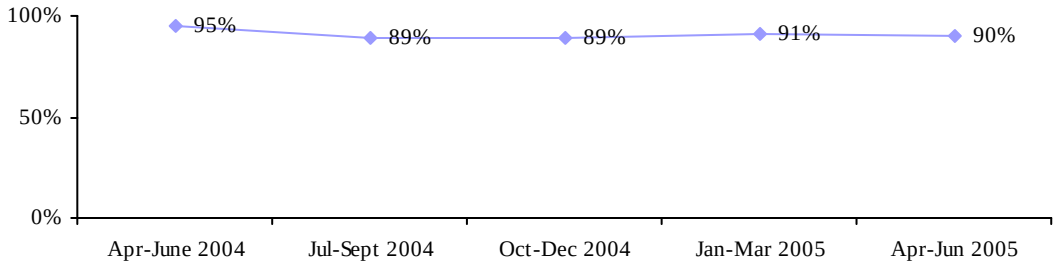
Birth rates for Hawaii for April to June 2005 are as follows:

Month	Births
April	1,215
May	1,209
June	1,172

Screen, Assessment, and Accepted Referral Rates

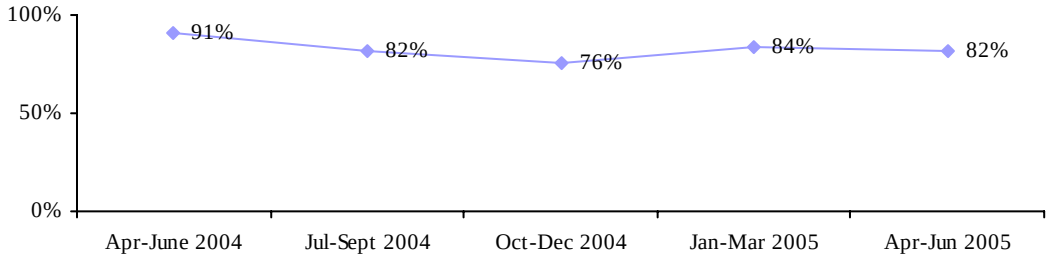
Screen rate: The quarterly early identification (EID) screen rate (Graph 2) has been consistent at an average of 90% over the past year.

Graph 2. Oahu EID Quarterly Screen Rate April 2004 through June 2005.



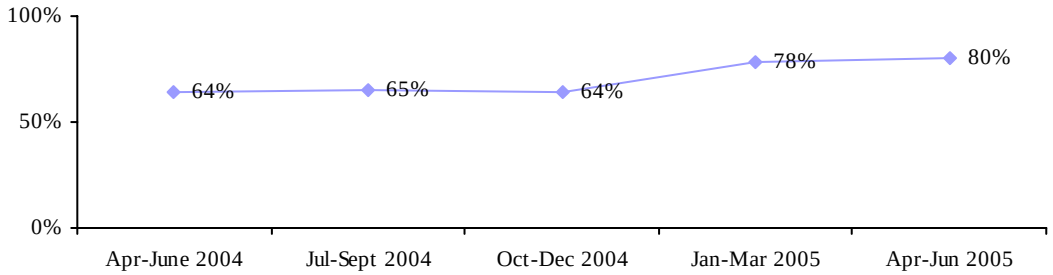
Assessment rate: The quarterly EID assessment rate (Graph 3) for this quarter is 82%. Factors that may contribute to the fluctuations in rate include staff turnover and vacancies. To address common barriers to acceptance of services, Healthy Start is developing a standardized protocol for presentation of program services.

Graph 3. Oahu EID Quarterly Assessment Rate April 2004 through June 2005.



Referral rate: The quarterly EID referral rate (Graph 4) was 80%. The Quality Assurance Specialist has increased efforts with specific new strategies toward achieving significant and consistent improvement toward a standard of 85% referral rate.

Graph 4. Oahu EID Quarterly Referral Rate April 2004 through June 2005.



New Enrollment

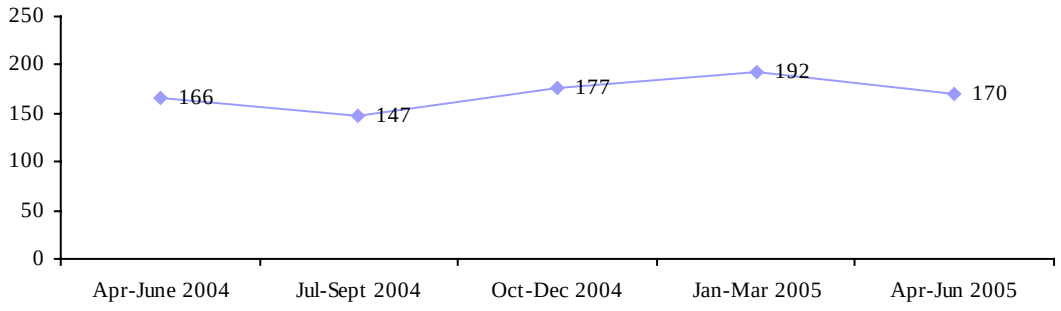
A total of 510 infants and toddlers were newly enrolled in home visiting services during this quarter (Table 2), a decrease of 11.4% from the previous quarter. Factors contributing to fluctuations in enrollment include varying number of births, varying number of positive screens/assessments, voluntary nature of acceptance of referrals to home visiting services, staff turnover, and protocols for addressing barriers to acceptance. The average monthly new enrollment statewide for this quarter is 170 (Graph 5).

Table 2. Healthy Start New Enrollment Data from April to June 2005

		Island					
Month	New Enrollment*	Oahu	East Hawaii	West Hawaii	Maui/ Lanai	Kauai	Molokai
April	174	111	14	19	17	13	0
May	177	127	10	11	25	4	0
June	159	121	16	8	12	2	0

* Does not include prenatal enrollments.

Graph 5. Healthy Start New Monthly Enrollment from April 2004 to June 2005



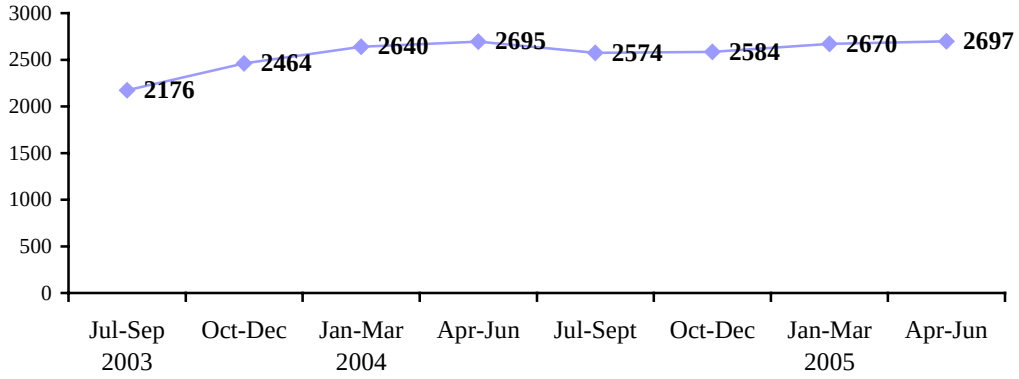
Active Enrollment

The monthly active enrollment (families remaining in home visiting services) has increased over the past 3 quarters (Table 3). The average quarterly enrollment for April to June 2005 (Graph 6) showed an increase of 1.0% from the third quarter (January to March 2005) and an increase of 4.4% from the second quarter (October to December 2004). The average monthly active enrollment statewide for this quarter is 2,697.

Table 3. Healthy Start Monthly Active Enrollment for April to June 2005

Month	Active Enrollment	Island					
		Oahu	East Hawaii	West Hawaii	Maui/ Lanai	Kauai	Molokai
April	2,697	1,789	268	219	233	138	50
May	2,707	1,809	249	219	242	138	50
June	2,688	1,819	242	215	237	132	43

Graph 6. Healthy Start Average Quarterly Enrollment from July 2003 to June 2005



Service Gaps

The tables below provide information on service gaps for EIS, PHNB, and Healthy Start providers for April-June 2005. Service gaps are divided into two types: full service gaps where no services were provided to the child, and partial service gaps where alternative services were provided. For children receiving multiple services, when a specific therapist is not available, there is generally a partial service gap, since another therapist, using a transdisciplinary format, will provide services. If the child requires only 1 service (e.g., speech therapy) and a therapist is unavailable to provide direct services, there will be a full service gap. When this occurs, the care coordinator typically will provide information on activities that the family can use with their child to support his/her development until a provider is available.

Full Service Gaps

The total number of monthly full service gaps increased from 27 full gaps last quarter to 36 full gaps this quarter, affecting 31 children (duplicated count) (Table 4). There were 23 children (unduplicated count) impacted over the quarter, with 8 children having gaps over more than one month.

Table 4. Full Service Gaps by Month

Service Gap		April	May	June	Total
Occupational Therapy		0	1 (Maui)	2 (Oahu) 1 (Hawaii) 2 (Maui)	6
Physical Therapy		0	0	1 (Maui)	1
Speech Therapy		2 (Oahu) 1 (Hawaii)	5 (Oahu) 1 (Hawaii) 1 (Maui) 2 (Kauai)	8 (Oahu) 4 (Maui) 2 (Kauai)	26
Special Instruction		1 (Hawaii)	0	0	1
Psychological Services – Skills Trainer		0	1 (Oahu)	1 (Oahu)	2
Total Number of Monthly Full Gaps	Oahu	2	6	11	19
	Maui	0	2	7	9
	Hawaii	2	1	1	4
	Kauai	0	2	2	4
	Total	**4**	**11**	**21**	**36**
Total Number of Children *(duplicated)*	Oahu	2	5	8	15
	Maui	0	2	6	8
	Hawaii	2	1	1	4
	Kauai	0	2	2	4
	Total	**4**	**10**	**17**	**31**
Total Number of Children *(unduplicated)*	Oahu	-	-	-	11
	Maui	-	-	-	7
	Hawaii	-	-	-	3
	Kauai	-	-	-	2
	Total	-	-	-	**23**

Partial Service Gaps

The total number of monthly partial service gaps (Table 5) also increased from 99 partial gaps last quarter to 118 this quarter, affecting 112 children (duplicated count). There were 71 children (unduplicated count) impacted over the quarter, with 41 children having gaps over more than one month.

Table 5. Partial Service Gaps by Month

Service Gap		April	May	June	Total
Occupational Therapy		5 (Oahu) 2 (Maui)	7 (Oahu)	1 (Oahu) 9 (Maui)	24
Physical Therapy		3 (Maui)	1 (Hawaii) 2 (Maui)	3 (Maui) 3 (Hawaii)	12
Special Instruction		2 (Oahu)	2 (Oahu)	1 (Oahu)	5
Speech Therapy		6 (Oahu)	15 (Oahu) 4 (Maui)	13 (Oahu) 6 (Maui)	44
Vision Services		4 (Oahu)	4 (Oahu)	4 (Oahu)	12
Psychological Services – Skills Trainer		4 (Oahu)	11 (Oahu)	2 (Oahu)	17
Interpretation Services		1 (Hawaii)	1 (Hawaii)	1 (Oahu) 1 (Hawaii)	4
Total Number of Partial Gaps	Oahu	21	39	22	82
	Maui	5	6	18	29
	Hawaii	1	2	4	7
	Total	**27**	**47**	**44**	**118**
Total Number of Children *(duplicated)*	Oahu	21	36	21	78
	Maui	5	6	16	27
	Hawaii	1	2	4	7
	Total	**27**	**44**	**41**	**112**
Total Number of Children *(unduplicated)*	Oahu	-	-	-	47
	Maui	-	-	-	20
	Hawaii	-	-	-	4
	Total	-	-	-	**71**

Reasons for Gaps

There are several reasons for gaps consistent across islands:

Staff Shortages and/or Vacancies. The main reason for gaps (both full and partial) is staff vacancies. This was particularly relevant this quarter in the area of speech-language therapy on Oahu and Maui and occupational therapy on Maui. Imua (Maui's early intervention provider) is continually recruiting for additional staff, but due to being on a neighbor island and salary differentials between Maui and the mainland, recruitment continues to be difficult.

Vacation/Sick Leave. Gaps also occur when staff is on vacation and/or sick leave, as there generally are not additional providers to fill in and meet service requirements. As noted in the section above, programs usually respond by revising schedules so that all children receive at least some services identified.

Providing Services on Weekends or After Work Hours and at Homes of Families. Another reason for gaps is the inability to provide services on weekends or after work hours and at families' home, to meet family needs. While programs attempt to schedule services at times and places convenient to families, there are generally fewer service options during weekends and after hours. Also, with increasing numbers of children and vacant positions, program staff may not always be available to provide home-based services. Programs will generally try to serve the child during work hours and at their center while they work them into their "after hours" and/or "at home" schedule. This is not always possible and the result is a service gap.

Scheduling Errors/Lack of Documentation. On occasion, program staff will inadvertently not contact a family to schedule a service identified on the IFSP. As soon as this is identified, the family is contacted to schedule the missing appointment, but it may still result in a service gap. Similarly, staff may not document that the service did occur, resulting in difficulty confirming that the service occurred.

Transfers to Programs. With the expansion of early intervention programs, children are being transferred from services provided by fee-for-service providers to program staff. There were instances this quarter when service gaps occurred due to scheduling errors at the new program. As the new programs are more stabilized, this should occur less frequently.

Actions to Reduce Gaps

1) All three new early intervention programs on Oahu are accepting referrals for newly identified children and accepting transfers from fee-for-service providers. Although there have been gaps due to transfer issues (described above), it is expected that there will be fewer service gaps and more comprehensive services for eligible children and their families on Oahu.
2) POS programs are in the process of revising their budgets for FY 2006. They will be able to review their salary ranges to determine if salaries need to be increased in order to attract more therapists.
3) EIS continues to work with EI program staff to review different service delivery models, including the use of transdisciplinary services, with consultation by other therapists, to meet the outcomes listed on the IFSP. While many children enrolled in early intervention programs receive transdisciplinary services, some therapists do not use this service option. Additional training in the transdisciplinary service delivery method continues to be provided to ensure that recommended IFSP services are appropriate.

All children served at early intervention programs (as compared to receiving services from fee-for-service providers), who had a partial service gap, received other services, generally through a transdisciplinary model of service delivery to support the overall needs of the child and family.

Personnel

Goal: 90% of EIS social work positions are filled.

EIS has a total of 48 social work positions statewide. Forty-four (44) positions provide care coordination services. The remaining 4 positions are administrative and are included in the data on administrative positions. At the end of June 2005, 39 of the 44 state social worker/care coordinator positions, or 89%, were filled. Vacant positions are on Oahu (2-EIS), Maui (1), and Hawaii (2), in Hilo and North Hawaii. All positions at the DOH ECSPs are filled. Recruitment has been difficult due to the length of time to receive lists. Individuals have expressed interest in these state positions and will be able to apply as soon as the recruitment period reopens. Although 89% are filled, three Oahu staff are on maternity leave, which impacts other social workers/care coordinators and the ability to meet required timelines.

The following table provides information on the 44 DOH social worker/care coordinator positions, by island and statewide as of June 2005.

Table 6. Percentage of EIS Social Work/Care Coordinator Positions that are Filled, by Island, as of June 2005.

Island	SW Positions Total #	SW Positions Filled #	SW Positions Filled %
Oahu	29	27	93%
Hawaii	7	5	71%
Maui	5	4	80%
Kauai	3	3	100%
Total	**44**	**39**	**89%**

Not included in the above table are the following 6 positions (5.0 FTE) that provide care coordination and are funded by the POS contracts: 0.5 FTE care coordinator position for Molokai's Ikaika program; 0.5 FTE social work position for Salvation Army; 1.0 FTE social worker for Imua on Maui; 2.0 FTE social work positions for the Easter Seals Kapolei POS program on Oahu; and 1.0 FTE for the Easter Seals Waipahu POS program on Oahu. Funds were included in the Ikaika, Salvation Army, Kapolei, and Waipahu programs as there are no designated DOH social work positions assigned to these programs. Funds were provided to Imua as the above five Maui state positions were not sufficient for their caseload.

Other Changes to Support Care Coordination Needs

As more children are referred to community-based early intervention programs, the EIS social work positions are supporting ECSP and POS programs. Two positions are supporting the new Kapiolani Medical Center (KMC) Central EI Program, two positions are supporting the Easter Seals Kailua Program, and two additional positions are supporting Easter Seals Sultan. One position is shared between the Leeward ECSP and KMC Early Intervention Program (Mobile Team), due to their increased caseloads. The Imua contract was recently amended to add an additional care coordinator (for a total of 2) due to their high caseloads and their coverage of the entire island of Maui as well as Lanai. This position will be recruited for as soon as additional modification to the IMUA contract for funding to cover the cost of this position is added.

EIS continues to closely monitor the enrollment of children in the new POS programs to ensure that assigning social workers from the EIS Care Coordination Unit will not negatively impact the ability of this unit to provide care coordination and social work support to the families still being assigned to this unit.

Goal: 90% of EIS direct service positions are filled.

EIS has 44 direct service positions statewide. These positions include early intervention therapists (speech-language pathologists, occupational therapists and physical therapists), psychologists, special education teachers, vision and hearing specialists, a nutritionist, and paraprofessionals. Not included are the Early Childhood Services Unit (ECSU) supervisor and ECSP Managers, as they spend the majority of their time providing administrative supervision and support to program staff. They are included in the count of administrative positions in Table 8. At the end of June 2005, 38 of the 44 direct service positions, or 86%, were filled. Table 7 below provides information on direct service positions statewide and by island.

Table 7. EIS Direct Service Positions by Island, as of June 2005.

Island	Direct Service Positions – Total #	Direct Service Positions – Filled #	Direct Service Positions – Filled %	Vacant Positions
Oahu	38	33	87%	OT III-1, PT III-1, PMA II-1; SLP-2
Hawaii	6	5	83%	SLP IV-1
Total	**44**	**38**	**86%**	–

Note: PT = physical therapist; SLP = speech-language pathologist; PMA = paramedical assistant

In addition to EIS direct service staff, EIS has over fifty contracts with fee-for-service providers who support the direct service staff. As noted in the previous section on Service Gaps, these contracted providers serve eligible infants and toddlers when there are staff vacancies and/or increases in referrals that cannot be met by either the ECSP or POS staff. They also help support the ECSPs when the service needs of enrolled children exceed staff capacity, as well as the EIS Care Coordination Unit children, where the majority is not served in early intervention programs.

However, now that the three new POS early intervention programs are operational and serving children, the need for fee-for-service providers has been reduced. In fact, several previous fee-for-service providers are now staff of the new EI programs. EIS is monitoring the impact of the new POS programs on funding needed by the fee-for-service providers, however, it is expected that the transfer of funds from fee-for-service providers to POS programs will be gradual. To support families and children changing providers, the new therapists will have two co-treatment sessions with the current therapists, to support the new provider taking over treatment and to ease the difficulty of families in changing providers.

Goal: 90% of EIS and Healthy Start central administration positions are filled.

Early Intervention Section

EIS has 60 administrative positions statewide, including unit supervisors and specialists in the areas of contracts, internal service testing, public awareness and training, computer support staff, accounting staff, clerical and billing staff, and the Public Health Administrative Officer (PHAO). Also included in the count of administrative positions are the Social Worker V who supervises the Care Coordination Unit social workers, two Social Worker II positions who support H-KISS, the Social Worker IV on the island of Hawaii who supervises seven social workers, ECSU supervisor, ECSP managers, and five Children & Youth (C&Y) Specialist IV positions who support quality assurance activities statewide.

Of the 60 administrative positions, 52 (87%) are filled. All vacant positions are on Oahu, which includes 4 staff to support third party billing, 2 clerk-typists to support the general administration of EIS, Child and Youth Specialist IV for Public Awareness/HEICC, and Public Health Administrative Officer III, to support the contracting needs of EIS. The billing positions were approved in the last biennium session (to be funded by the carveout funds), however, requirement has been delayed as a result of the change in the vacant positions from exempt to civil service. The two 3rd Party Billing Clerk positions are both vacant as the incumbents resigned to accept more lucrative positions in the private sector. Recruitment for the 2 clerk-typists will recommence as soon as the recruitment period

reopens in September or October. Recruitment for the PHAO position was completed and the selected applicant will begin July 1, 2005.

Table 8 provides information on the administrative positions statewide and by island:

Table 8. EIS Administrative Positions by Island, as of June 2005.

Island	Administrative Positions – Total #	Administrative Positions – Filled #	Administrative Positions – Filled %	Vacant Positions
Oahu	54	46	85%	Clerk-Typist-2; Billing Clerks-2; 3rd Party Billing Clerks-2; PHAO-1; Child & Youth Specialist (HEICC)-1
Hawaii	5	5	100%	–
Maui	1	1	100%	–
Total	**60**	**52**	**87%**	–

Healthy Start

Healthy Start has 9 administrative positions on Oahu. These positions include a program supervisor, registered professional nurse, research statistician, and other specialists in the areas of quality assurance, data management, and contract management. There is also support staff in clerical, billing, and statistics. At the end of June 2005, 67% of Healthy Start administrative positions were filled. Three positions (Program Supervisor, Children & Youth Specialist, and Statistics Clerk) were vacant and all are under recruitment. Quality Assurance Specialist acted as Program Supervisor. The contract management specialist position was vacant beginning July 1, 2005 and is now being converted to an Accountant III civil service position.

Goal: 90% of EIS caseloads will be no more than 1:45 weighted caseloads.

The "weight" of a caseload is determined by the number of hours needed per month per family for care coordination and social work services. A child who is "monitored" receives a weight of 0.25, a child who requires 3-5 hours/month is considered "moderate" and has a weight of 1, and a child who requires 6 or more hours/month of care coordination and social work services is considered "intense" and has a weight of 3. In addition, a weight of 1 is also given to the social worker "liaison" for any child served by an early intervention program whose care coordinator is from another agency (e.g., PHN, Healthy Start). This added weight is intended to support the time needed for the programs' social workers to collaborate with the care coordinator to ensure that timelines are met, services are provided, and their attendance at IFSP and other collaborative meetings.

Social Workers' Weighted Caseloads

Table 9 provides information on the percentage of social workers, by island, that have a weighted caseload of no more than 1:45. Data are provided on the 42 positions that provided care coordination, which includes 37 of the 39 filled DOH positions (2 were on maternity leave and therefore not available) that provided care coordination from Table 6 and the additional 5 filled POS positions funded via the POS contracts: Kapolei Easter Seals - 2.0 FTE, Waipahu Easter Seals - 1.0 FTE, Salvation Army - 0.5 FTE) and Ikaika (Molokai) - 0.5. Of the 42 positions, only 7 (14%) had weighted caseloads not more than 1:45, which was a decrease from 9 (21%) last quarter. With the vacant positions and staff

on maternity leave, it is not surprising that the social workers/care coordinators have high caseloads. However, even if all positions were filled (Table 10), the care coordination ratio still exceeds the 1:45 ratio on all islands except for Hawaii, and has increased to 1:45 on Hawaii. The care coordination caseload for Maui continues to be especially high.

Table 9. Social Work Positions (DOH and POS) with Weighted Caseloads Not More than 45, by Island, as of June 2005.

Island	# Social Workers Providing Care Coordination as of June 2004	Number with Weighted Caseload No More than 45	Percent with Weighted Caseload No More than 45
Oahu	28	4	14%
Hawaii	5	2	40%
Maui & Lanai	5	1	20%
Kauai	3	0	0%
Molokai	1	0	0%
Total	**42**	**7**	**17%**

Table 10 provides information on the status of care coordination ratio if all positions were filled.

Table 10. Projected Average Caseloads When All the Social Work Positions (DOH and POS) are Filled and Providing Care Coordination

Island	# Social Worker Positions for Care Coordination	%FTE Social Worker Positions for Care Coordination	Total Weighted Caseload	Average Weighted Caseload (Projected)
Oahu	35	32.25	1781	55
Hawaii	7*	7.00	314	45
Maui & Lanai	6	5.25	343	65
Kauai	3	3.00	155	55
Molokai	1	0.50	45	74
Total	**52**	**48.00**	**2638**	**55**

* There are 3 programs in different geographical areas of Hawaii: Hilo, Kona, and North Hawaii.

The high caseload continues to be a major concern.

Actions to Support Care Coordination

1) Contract modifications are in place to support the POS programs to hire additional social work/care coordinators as follows: Easter Seals Sultan, Easter Seals Kailua, Easter Seals Waipahu, Easter Seals Kapolei; KMC-Central; Easter Seals Kauai; Imua Family Services (Maui); and Ikaika (Molokai).
2) EIS is closely monitoring the boundaries of the state Early Childhood Services Programs (ECSP) to ensure they can meet the needs of their enrolled children. When caseloads exceed what is appropriate, the boundaries between the ECSP and neighboring POS programs are reviewed and revised.
3) Other early intervention staff (program managers and direct service staff) have assumed care coordination functions in addition to their primary roles. This is only a short-term solution as it can result in more service gaps if the direct service providers reduce their direct service time to assist in providing care coordination.
4) Overtime has been approved for EIS care coordinators so they can meet the needs of their families served and complete necessary paperwork.
5) Public health nurses (PHNs) continue to provide care coordination primarily for infants and toddlers with medical conditions and concerns, but also to children

referred from Child Welfare Services due to drug exposure. The December 2004 child count showed that the PHNs provided care coordination to 505 infants and toddlers with special needs. Although the number of infants and toddlers requiring care coordination from PHNB has remained between 494 and 528 over the past five years, there has been an increase in the complexity of medical needs of the children, which results in more time needed for PHN care coordination. Regular meetings with PHNB are scheduled to review the care coordination needs of infants and toddlers with medical concerns.

Change to A Non-Weighted Caseload Standard

The issue of continuing to use a "weighted" caseload or changing to a "non-weighted" caseload has been under consideration for almost a year. The main concern about continuing to "weigh" children is the difficulty of ensuring that all care coordinators are following the approved protocol in determining the "weight." For consistency, the Program Manager would need to monitor the assignment of "weight" which would impact the completion of other activities. Another concern is that the "weight" would not remain the same, as it would vary throughout a child's enrollment in early intervention. For example, it should be "intense" during intake, evaluation and IFSP development, decrease to "moderate" or "monitor" while services are provided on a regular basis, and then increase again during transition or times of family emergency. Determining how to assign children to care coordinators in a fair and equitable manner would be difficult. It appears that assigning by caseload number would be more effective, more equitable, and easier to monitor.

A request was made to early intervention programs on the mainland for data on their care coordination ratios and whether they use a "weighted" or "non-weighted" ratio. Five programs responded. All use a "non-weighted" ratio, and had ratios of: 1:30, 1:32, 1:35, 1:45 and 1:45-60. Reanalyzing Hawaii's data using a "non-weighted" formula showed that the majority of care coordinators had a 1:50-70 ratio, while only a few were at a more appropriate level of 1:35.

Because of the above information, EIS is planning to change its current weighted caseload standard to a non-weighted caseload standard beginning July 2005. Its proposed standard is a caseload ratio of 1:35-40. This number is based upon information from other Part C programs and concerns raised by EIS care coordinators, which include their inability to have sufficient time to adequately meet the needs of families, complete the required paperwork in a timely basis, and meet state and federal timelines. In addition, depending on overtime cannot be a long-term solution as it is not only inefficient, but it is currently leading to job dissatisfaction and eventual retention issues.

Training Opportunities

Early Intervention Section

Training provided and/or supported by EIS for April-June 2005 impacted 814 early interventionists, public health nurses, Healthy Start providers, Early Head Start staff, fee-for-service providers, community preschool staff, other community providers, and family members.

There were four major areas of training this quarter were: 1) IDEA Part C and Hawaii's Early Intervention System (3-day required training) to newly hired staff (including EIS-POS staff, PHNs, Healthy Start providers) and fee-for-service providers; 2) Statewide Individual Family Support Plan (IFSP); 3) supporting children with challenging behavior and the staff serving them; and 4) supporting children with hearing loss. The following is a list of training topics and number of attendees during this quarter:

- **Early Intervention Orientation, Day 1: Part C and Hawaii's Requirements.** Day 1 of the 3-day training focuses on IDEA Part C, Hawaii's implementation of IDEA, the eligibility and referral process, the philosophy of family-centered services, communication skills with families and family rights. Thirty-two (32) individuals from EIS State and POS Programs, PHNB, and Healthy Start attended trainings on Oahu and Maui.

- **Early Intervention Orientation, Day 2: IFSP and Care Coordination.** Day 2 of the 3-day training includes care coordination, the IFSP process, timelines, required components, and information on natural environments. A total of 33 individuals from EIS State and POS Programs, PHNB, and Healthy Start attended trainings on Oahu and Maui.

- **Early Intervention Orientation, Day 3: Transition.** Day 3 of the 3-day training includes information on transdisciplinary service provision, teaming, and transition. A total of 22 individuals from EIS State and POS Programs, PHNB and Healthy Start attended on Oahu and Maui.

- **Statewide IFSP.** Four hundred thirteen (413) individuals from EIS State and POS Programs, PHNB, and Healthy Start were trained on the recently developed and approved Statewide IFSP form. A total of 14 trainings were held on Oahu (10), Maui (1), Hawaii (1) Kauai (1) and, Molokai (1).

- **Supporting Children with Challenging Behaviors.** The Keiki Care Project Coordinator continues to provide trainings to support staff serving young children with challenging behaviors. *"Practical Approaches for the Challenged Teacher: Piecing Together the Behavior Puzzle"* was presented to 4 teachers at St. Joseph's School on Maui and to 8 teachers at the KCAA Na Lei Preschool on Oahu.

- **Supporting Infants, Toddlers with Hearing Loss and their Families.** Ten presentations/activities were provided to support 67 families and staff of children with hearing loss. The group presentations included: Castle Hospital nurses on sign language with medically fragile and non-verbal children; Oahu and Maui EI Programs on how to refer for support; and sign language awareness at a Baby Hui meeting. Individual support was provided to speech-language pathologists at Oahu, Maui, Hilo and North Hawaii EI Programs, and to one of the Deaf Mentors.

- **Hawaii's Early Intervention System.** Sixty-eight (68) DOE Principals, Student Services Coordinators, preschool special education teachers and related services staff attended a workshop on *"Little Kids and Katydids: Beginning Services for Our Infants and Toddlers."*

- **Transition.** Sixty-five (65) members of the STEPS teams attended the Hawaii STEPS Anniversary Conference. The agenda included information on STEPS, Transition Survey data, and transition team updates.

- **Inclusion Project.** Inclusion Project updates were provided to staff of three early intervention programs on Oahu that impacted 22 individuals.

- **Sensory Integration.** Two workshops (35 individuals), on the relationship between sensory integration and challenging behaviors, were provided to Early Head Start staff and families enrolled in the Tripler Army Medical Center's Exceptional Family Member Program Autism Parent Support Group.

- **Other Trainings.** Other trainings provided this quarter included: 1) Two workshops on *"Including Children with Special Needs"* were provided to 30 staff of the Navy Child Development Homes Program; 2) Fifteen (15) Child Welfare Service administrators were provided awareness of the EI System and Internal Reviews.

- **Conference Support.** EIS supported staff and family members to attend the Special Parent Information Network (SPIN) Conference.

- **Informal Trainings/Consultants.** In addition to the more formal training discussed above, staff often provide informal, in-person and telephone support to families and staff of early intervention programs and community preschools.

Healthy Start

Healthy Start has a commitment to continued quality improvement and regularly incorporates training opportunities into this process. Healthy Start administrative program staff and representatives from each Purchase-of-Service Provider (POSP) began meeting monthly in May 2005. These meetings are an opportunity for continued collaboration on program development and education on timely issues, such as IDEA, Part C compliance activities. Further strengthening of the Early Intervention System continues as Healthy Start administrative staff and POSP take an active role in system development and improvement, including but not limited to, the IFSP and monitoring activities.

The training POSP provided the following training:

- **Advanced Supervisor Training – Module II.** Module II continues to build on concepts from Module I by developing strategies utilizing the reflective process with staff, and identifying and documenting environmental risk factors. Module II was offered May 23-26, 2005.

- **Healthy Families America (HFA) Prenatal Project "Great Beginnings Start Before Birth".** A four-day training on a prenatal curriculum was designed to improve, strengthen, and ultimately provide standards for the practice of prenatal home visiting services, including addressing challenging lifestyle behaviors such as family violence, mental health, and substance use. A unique quality of this

training is the strong father involvement component. This curriculum is required in the new contract period. Dates offered were April 11-13, 2005 and May 16-18, 2005.

- **Additional training.** Essential program specific training is required within six months of hire for all Healthy Start staff, including program directors. Community and content experts provide it, with the focus on the latest research and best practice. Child development topics covered during this quarter included: Responsive Process (April 6, 2005); Brain Development (April 8, 2005); Discovery on Infancy (April 20, 2005); Language Development (April 22, 2005); and Developmental Milestones (April 27, 2005). The family resiliency topic covered this quarter was Working with Teen Parents, a two day training (June 1-2, June 8-9, and June 22-23, 2005).

- **Intensive Role Specific Training for Family Assessment Workers.** A four-day (April 4-7, 2005) training covering the family assessment worker's core tasks and responsibilities, according to HFA standards, with a fifth day (April 8, 2005) covering the basic aspects of supervision.

- **Intensive Role Specific Training for the Child Development Specialist (CDS) position.** All new CDS attended this one-day seminar (April 25, 2005) to review role and responsibilities in relation to the model. CDS Supervisors were also strongly urged to attend.

In addition, the Healthy Start program provided the following training for all Clinical Specialists, Child Development Specialists and their supervisors. This curriculum will be required in the new contract period:

- **"Making Parenting A Pleasure" curriculum training.**
  This curriculum addresses stress, isolation, lack of parenting information and social support for families and may be presented in a group or home visiting setting. The curriculum and associated activities may be adapted to meet the needs and interests of the families. In a home visiting setting, the home visitor may adapt the activities in the curriculum to meet the needs, styles, and goals of the families. The two-day training was on June 23-24, 2005 and June 27-28, 2005.

Quality Assurance

Early Intervention Section

The EIS approach to quality assurance (QA), through a variety of specific activities, is that the State is assured that 1) all children under the age of 3 with developmental delays and their families are provided, through a family-centered, community-based, coordinated process, the necessary early intervention services to meet their needs; and 2) all services are provided in conformance with federal IDEA Part C and state requirements.

Recent feedback from the Office of Special Education Programs (OSEP) (July 6, 2005) on the submission of last year's Annual Performance Report reported continued non-compliance in the following areas: 1) not ensuring that the State's monitoring process adequately identified and corrected areas of non-compliance; 2) not providing all children with timely Comprehensive Developmental Evaluations (CDE); 3) not including complete information on "Present Level of Development" in IFSPs; and 4) not providing timely transition activities, including Transition Plans, Transition Conferences, Transition Notices.

Several years ago it was determined that the most important ingredient of becoming compliant was to develop a single system to serve all Part C children. Because Part C children are served by staff of different DOH Divisions (Family Health Services Division and Community Health Nursing Division) and Branches (Children with Special Health Needs Branch, Maternal Child Health Branch, Public Health Nursing Branch), it was vital that everyone have the same philosophy and practice. To reach this end, a variety of activities occurred, including:

1) A required 3-day training on IDEA Part C requirements was developed and systematically presented statewide to all Part C providers.
2) A single set of monitoring tools was developed and implemented last year and the resulting data was analyzed and shared statewide.
3) A family survey was developed and disseminated by all Part C Programs to determine how Hawaii's EI System could better meet family needs.
4) A decision to identify specific and appropriate tools to be used in completing the Comprehensive Developmental Evaluation to determine eligibility for Part C services.
5) A decision to develop a statewide IFSP that would be used by all programs, including EIS, PHNB, and Healthy Start. A committee of representatives of all Part C programs and families developed the IFSP. After piloting, training was provided to all staff statewide, with an implementation date of July 1, 2005.
6) Quality Assurance Specialists were hired to both support EIS Program Improvement and monitor for compliance.
7) Multiple conversations were held with OSEP staff to clarify issues of non-compliance and to agree on the wording of the Transition Notice.
8) Four new Purchase of Service EI Programs were funded so that more children and families would be served by multidisciplinary programs instead of discipline-specific fee-for-service providers.
9) Statewide forms were developed including the: Transition Notice, Transition Conference Meeting Notification, and IFSP Meeting Invitation.

10) POS Programs will be provided additional funds to hire more care coordinators so that caseloads will be lowered and requirements will be timely.

However, even though the above successful activities occurred to develop a single system, the data presented in the 2003-2004 Annual Performance Report did not show sufficient improvement, and as a result, Special Conditions were attached to Hawaii's Part C Grant Award.

Over the next quarter there will be changes in service provision and increased monitoring to assure that the changes successfully impact the non-compliance.

Child/Family Outcomes
Activities will continue to determine the effectiveness of EI in supporting outcomes of children and their families.

Internal Reviews
Internal Reviews (which utilize the Felix Service Testing protocol) provide the opportunity for an objective observation of a child's and family's progress and to what extent the system supports the child and family and will continue. However, because of the need to assure smooth transitions, one of the two children reviewed per complex will be in the transition process to DOE Preschool Special Education. This will provide additional information to both confirm that Part C children are being provided the required transition activities and to examine the collaboration between Parts B and C in the area of transition.

Efforts to Support Concerns Raised During Internal Reviews: EIS has developed new procedures, to begin in September 2005, to provide feedback to the agencies that provide care coordination and/or services to children reviewed so they can improve practice.

- The EIS Internal Review Coordinator will summarize the results from each review (regardless of whether the child passes or fails) for the care coordinating Program/Section. Information provided will include strengths, needs, and recommendations.
- There will be increased involvement with the Complex Improvement Process. This is being developed in conjunction with the DOE.
- Action plans will be developed and added to the Program's Improvement Plan if a child does not pass either the Child or System Review.

In addition, EIS is now represented on the Interagency Quality Assurance Committee to support interagency collaboration in the area of quality assurance. Other members include representatives of the Department of Education, DOH Developmental Disabilities Division, DOH Child and Adolescent Mental Health Division, Department of Human Services Child Welfare System, and Hawaii Families as Allies.

Participation in Nationwide Efforts to Identify Appropriate Child and Family Outcomes
Hawaii's Part C Coordinator was invited to participate in a workgroup organized by the Early Childhood Outcomes (ECO) Center to identify appropriate child and family outcomes that will be presented to OSEP as possible nationwide child and family outcomes. In addition, the Stanford Research Institute (SRI) in collaboration with EIS submitted and received funding for a grant proposal to identify and pilot outcome indicators with all Hawaii's Part C programs. Hawaii may choose to utilize the national outcomes being developed, or expand these to be more specific to Hawaii's population.

Roles and Responsibilities of EIS Quality Assurance Specialists

The 5 Quality Assurance (QA) Specialists continue to expand their roles in the area of quality assurance through the following activities/strategies to support compliance:

- Monitor child charts.
- Review quarterly monitoring data with Program Managers to help determine how to increase compliance.
- Support programs in developing and implementing Improvement Plans to meet identified needs based on monitoring results.
- Facilitate statewide IFSP trainings.
- Participate in collaborative meetings for staff of different agencies that serve the same child (e.g., Imua Family Services, Healthy Start, and PHNB).
- Act as a resource regarding IDEA Part C requirements.
- Participate in the Internal Review process.
- Attend DOE Complex/District Quality Assurance meetings.
- Participate in STEPS teams.
- Attend Community Council meetings.
- Attend EIS Program Manager meetings to support their understanding of issues that impact all early intervention programs.

Healthy Start

Healthy Start staff have actively participated in developing and implementing the state's Early Intervention system to assure that all environmentally at-risk children age 0-3 years and their families are provided, through a family-centered, community-based, coordinated process, the necessary early intervention services to meet their needs. This includes full participation in all Early Intervention quality assurance activities. POSP have specific quality improvement plans implemented and these plans include improvement related to the IFSP (the focus of Year 2 EI System Focused Monitoring) and transition. Beyond quality assurance activities related to IDEA, Part C, Healthy Start is also engaged in specific quality improvement activities related to program requirements. The focus the fourth quarter was on establishing quality control procedures related to data collection, entry, analysis, and reporting to ensure credibility and fiscal accountability.

Funding

Early Intervention Section

A total of $8,704,521 was both appropriated and allocated for FY 2004. A total of $8,680,021 was appropriated and $8,799,576 was allocated for FY 2005 (difference due to additional funds authorized by the Legislature for collective bargaining increases). The majority of the first quarter allocation supports POS and fee-for-service contracts.

Table 11. EIS Allocations and Expenditures/Encumbrances – State Funds

	Allocation	Cumulative Allocation to End of Quarter	Cumulative Expenditures/ Encumbrances at End of Quarter[1]
Fiscal Year 2004			
1st quarter – July-Sept. 2003	5,110,381	5,110,381	5,273,077
2nd quarter – Oct.-Dec. 2003	1,382,500	6,492,881	6,572,738
3rd quarter – Jan.-Mar. 2004	1,105,000	7,597,881	8,137,074
4th quarter – Apr.-June 2004	1,106,640	8,704,521	9,305,774
Fiscal Year 2005			
1st quarter – July-Sept. 2004	5,260,161	5,260,161	5,315,096
2nd quarter – Oct.-Dec. 2004	1,345,500	6,605,661	6,818,039
3rd quarter – Jan.-Mar. 2005	1,105,500	8,011,161[2]	8,008,813
4th quarter – Apr.-June 2005	1,088,415	9,399,576	9,420,630 [3]

[1] Source: Financial Accounting and Management Information System (FAMIS) report.
[2] Includes $300,000 transferred in from Healthy Start.
[3] Information as of 7/6/05.

EIS also receives federal Part C funds (Table 12) for early intervention services. These funds increased from $2,127,667 for FY04 to $2,194,384 for FY 2005.

Table 12. EIS Allocations and Expenditures/Encumbrances – Federal Part C Funds

	Allocation	Cumulative Allocation to End of Quarter	Cumulative Expenditures/ Encumbrances at End of Quarter[1]
Fiscal Year 2004			
1st quarter – July-Sept. 2003	1,029,505	1,029,505	665,674
2nd quarter – Oct.-Dec. 2003	384,000	1,413,505	1,023,325
3rd quarter – Jan.-Mar. 2004	387,500	1,801,005	1,428,830
4th quarter – Apr.-June 2004	325,662	2,127,667	2,127,667
Fiscal Year 2005			
1st quarter – July-Sept. 2004	995,671	995,671	663,772
2nd quarter – Oct.-Dec. 2004	416,515	1,412,186	686,145
3rd quarter – Jan.-Mar. 2005	426,000	1,838,186	1,054,774
4th quarter – Apr.-June 2005	428,227	2,266,413	1,361,643 [2]

[1] Source: FAMIS Report
[2] Information as of 7/6/05

Additional funding for EIS services has been from the EI Special Fund into which the Medicaid reimbursement for EI services are deposited.

Healthy Start

In FY 2004, a total of $19,217,620 in State and Tobacco funds were appropriated and allocated. The 2003 Legislature had reduced State funds $2.5 million due to the decreased need for POSP contract funds, and replaced $5,336,023 of State funds with Tobacco funds. During the fourth quarter of FY 2004, as a result of the initial performance of new POSP and the resulting lower than expected expenditures, $475,000

of state funds were transferred to EIS to support their deficit; this reduced the total Healthy Start state funds to $13,406,597.

In FY 2005, a total of $16,625,102 in State and Tobacco funds were appropriated and allocated. The 2004 Legislature reduced the FY 2005 state appropriation from $13,969,953 to $11,877,435, and reduced the Tobacco funds from $5,247,667 to $4,747,667. During FY 2005, as a result of lower than expected expenditures, $600,000 of state funds were transferred to EIS to support their deficit; this reduced the total Healthy Start state funds to $11,277,435.

The following table shows allocations and expenditures/encumbrances:

Table 13. Healthy Start Allocations and Expenditures/Encumbrances (Source: FAMIS report)

	Allocation	Cumulative Allocation to End of Quarter	Cumulative Expenditures/ Encumbrances at End of Quarter
Fiscal year 2004 [1]			
1st quarter – Jul.-Sept. 2003	18,882,063	18,882,063	14,094,945
2nd quarter – Oct.-Dec. 2003	161,188	19,043,251	15,803,950
3rd quarter – Jan.-Mar. 2004	87,185	19,130,436	17,269,484
4th quarter – Apr.-June 2004	(387,816) [2]	18,742,620	18,657,190
Fiscal year 2005 [3]			
1st quarter – Jul.-Sept. 2004	16,363,548	16,363,548	16,825,456
2nd quarter – Oct.-Dec. 2004	87,185	16,450,733	15,682,408
3rd quarter – Jan.-Mar. 2005	(512,815) [4]	15,937,918	15,860,660
4th quarter – Apr.-June 2005	87,184	16,025,102	15,923,758 [5]

[1] State funds ($13,881,597) + Tobacco funds ($5,336,023).
[2] $475,000 was transferred to EIS in the fourth quarter of FY 2004, reducing State funds to $13,406,597.
[3] State funds ($11,877,435) + Tobacco funds ($4,747,667).
[4] Quarter allocation of $87,185 less $600,000 transferred out to EIS in March 2005
[5] Information as of 5/31/05. June 2005 financial report unavailable.

Summary

Strengths in the early intervention system from April-June 2005 include:

- ⇨ Training for the statewide IFSP was completed in June 2005. Statewide implementation is planned for July 2005.
- ⇨ A decision was made to review one "transition" child during School Year 2005-2006 Internal Reviews to help support improved transition.
- ⇨ All three new POS programs are fully operational.
- ⇨ POS programs have been approved to increase the number of care coordinators to help reduce the care coordination ratio.
- ⇨ The care coordination ratio methodology was reviewed. It was determined that a "non-weighted" 1:35-40 ratio would be a better caseload standard.
- ⇨ All Part C programs are working diligently to correct the areas of non-compliance identified by OSEP.
- ⇨ Medicaid reimbursements for EI services were received and have been used to support the EIS deficit.

- ⇨ Dedicated direct service staff at EIS and public and private early intervention programs is working diligently to meet the needs of the expanding number of children identified with developmental delays statewide and their families.
- ⇨ On-going meetings between EIS, Healthy Start, and PHN staff support collaboration and continuity for Hawaii's Part C eligible children.
- ⇨ On-going collaboration with DOE support the transition of children from DOH Part C programs to DOE preschool programs.

Challenges to the early intervention system from April-June 2005 include:

- ⇨ The increase in the identification of children with developmental delays has led to an increase in care coordination ratios. Changes noted above are now in place to reduce the ratios.
- ⇨ Hawaii Part C has been identified to be in non-compliance and Special Conditions were attached to the FFY 2005 Grant Award.
- ⇨ Increased monitoring is necessary to determine if the non-compliance is corrected.
- ⇨ There is not a Part C data system to determine statewide compliance. Each Agency must adapt or develop its own system to determine compliance.
- ⇨ The increased number of children identified as IDEA Part C eligible has resulted in increased costs in meeting their service needs.
- ⇨ Employment and retention of experienced early intervention staff impacts the ability to meet OSEP requirements.
- ⇨ EIS needs additional funding to offset the continuing budget deficits, as the continuing late payments impacts the willingness of POS programs to hire additional staff to meet service needs.
- ⇨ Continued training is needed for Healthy Start agencies on strategies and quality improvement efforts to meet standards.